

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0045948</u></p> <p>Facility Name: <u>LEE COUNTY NURSING AND REHAB CENTER</u></p> <p>Address: <u>800 DIVISION STREET</u> <u>DIXON</u> <u>61021</u> Number City Zip Code</p> <p>County: <u>LEE</u></p> <p>Telephone Number: <u>815-284-3393</u> Fax # <u>815-284-2066</u></p> <p>IDPA ID Number: <u>47-0885813001</u></p> <p>Date of Initial License for Current Owners: <u>6/1/1998</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>KEN MARX, BKD, LLP</u> Telephone Number: <u>314-231-5544</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1165 678 1297 824" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1297 678 1942 743">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1297 743 1942 808">(Type or Print Name) <u>CLARK RIBORDY, THCSLLC, MGT. CO.</u></td> </tr> <tr> <td data-bbox="1165 824 1297 1036" rowspan="4">Paid Preparer</td> <td data-bbox="1297 824 1942 889">(Title) _____</td> </tr> <tr> <td data-bbox="1297 889 1942 954">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1297 954 1942 1019">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1297 1019 1942 1084">(Firm Name & Address) _____</td> </tr> <tr> <td colspan="2" data-bbox="1165 1084 1942 1115"> (Telephone) <u>()</u> Fax # <u>()</u> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>CLARK RIBORDY, THCSLLC, MGT. CO.</u>	Paid Preparer	(Title) _____	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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Facility Name & ID Number LEE COUNTY NURSING AND REHAB CENTER# 0045948 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>91</u>	Skilled (SNF)	<u>91</u>	<u>33,306</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>91</u>	TOTALS	<u>91</u>	<u>33,306</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,930</u>	<u>10,482</u>	<u>2,417</u>	<u>28,829</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,930</u>	<u>10,482</u>	<u>2,417</u>	<u>28,829</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.56%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A - None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/1/1998

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/1/1998 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 91 and days of care provided 2,417Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CE # 0045948 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	138,653	4,225	8,597	151,475		151,475	(4,798)	146,677		1
2	Food Purchase		126,257		126,257		126,257	(559)	125,698		2
3	Housekeeping		8,904	96,046	104,950		104,950		104,950		3
4	Laundry		6,925	64,037	70,962		70,962		70,962		4
5	Heat and Other Utilities			106,582	106,582		106,582		106,582		5
6	Maintenance	24,294	6,630	45,276	76,200		76,200		76,200		6
7	Other (specify):*			3,273	3,273		3,273		3,273		7
8	TOTAL General Services	162,947	152,941	323,811	639,699		639,699	(5,357)	634,342		8
	B. Health Care and Programs										
9	Medical Director			6,831	6,831		6,831		6,831		9
10	Nursing and Medical Records	1,090,826	45,833	7,650	1,144,309		1,144,309		1,144,309		10
10a	Therapy		238	135,288	135,526		135,526		135,526		10a
11	Activities	66,935	101	3,798	70,834		70,834		70,834		11
12	Social Services	55,096	93	2,857	58,046		58,046		58,046		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,212,857	46,265	156,424	1,415,546		1,415,546		1,415,546		16
	C. General Administration										
17	Administrative	49,517			49,517		49,517		49,517		17
18	Directors Fees										18
19	Professional Services			276,520	276,520		276,520		276,520		19
20	Dues, Fees, Subscriptions & Promotions			22,406	22,406		22,406	(15,613)	6,793		20
21	Clerical & General Office Expenses	78,364	16,877	25,616	120,857		120,857	(122,416)	(1,559)		21
22	Employee Benefits & Payroll Taxes			273,850	273,850		273,850		273,850		22
23	Inservice Training & Education			3,244	3,244		3,244		3,244		23
24	Travel and Seminar			5,022	5,022		5,022		5,022		24
25	Other Admin. Staff Transportation			7,214	7,214		7,214		7,214		25
26	Insurance-Prop.Liab.Malpractice			127,548	127,548		127,548		127,548		26
27	Other (specify):*										27
28	TOTAL General Administration	127,881	16,877	741,420	886,178		886,178	(138,029)	748,149		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,503,685	216,083	1,221,655	2,941,423		2,941,423	(143,386)	2,798,037		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CENTER #0045948 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,892	5,892		5,892	35,246	41,138			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,384	16,384		16,384	(40)	16,344			32
33	Real Estate Taxes			32,102	32,102		32,102		32,102			33
34	Rent-Facility & Grounds			101,135	101,135		101,135	(95,332)	5,803			34
35	Rent-Equipment & Vehicles			727	727		727	1,115	1,842			35
36	Other (specify):*											36
37	TOTAL Ownership			156,240	156,240		156,240	(59,011)	97,229			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,781	22,327	95,108		95,108		95,108			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,754	53,754		53,754		53,754			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		72,781	76,081	148,862		148,862		148,862			44
45	GRAND TOTAL COST											
	(sum of lines 29, 37 & 44)	1,503,685	288,864	1,453,976	3,246,525		3,246,525	(202,397)	3,044,128			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(4,798)	1		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(40)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(559)	2		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(2,993)	21		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(18,997)	21		24
25 Fund Raising, Advertising and Promotional	(15,613)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(9,958)	21		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,958)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(149,439)	Var	34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (149,439)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (202,397)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39		X			39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
LEE COUNTY NURSING AND REHAB CENTER

Page 5A

ID# 0045948
Report Period Beginning: 1/1/2004
Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (9,958)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,958)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CENTER# 0045948

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(4,798)	0	0	0	0	0	0	0	0	0	0	(4,798)	1
2	Food Purchase	(559)	0	0	0	0	0	0	0	0	0	0	(559)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,357)	0	0	0	0	0	0	0	0	0	0	(5,357)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(15,613)	0	0	0	0	0	0	0	0	0	0	(15,613)	20
21	Clerical & General Office Expenses	(31,948)	(90,468)	0	0	0	0	0	0	0	0	0	(122,416)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(47,561)	(90,468)	0	0	0	0	0	0	0	0	0	(138,029)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,918)	(90,468)	0	0	0	0	0	0	0	0	0	(143,386)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CENTER# 0045948

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Tutera Health Care Services LLC	100%					
TI Dixon, LLC	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Building and Fixtures	\$	Tutera Health Care Services, Inc	100.00%	\$ 5,803	\$ 5,803 1
2	V	35 Moveable Equipment		Tutera Health Care Services, Inc	100.00%	1,115	1,115 2
3	V	21 Non-Capital	210,461	Tutera Health Care Services, Inc	100.00%	119,993	(90,468) 3
4	V	30 Depreciation		TI Dixon LLC	100.00%	35,246	35,246 4
5	V	34 Building Rent	101,135	TI Dixon LLC	100.00%		(101,135) 5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 311,596			\$ 162,157	\$ * (149,439) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CI # 0045948 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CENTER # 0045948 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Tutera Health Care Services, LLC
 Street Address 7611 State Line Road, Suite 301
 City / State / Zip Code Kansas City, MO 64114
 Phone Number (816) 444-0900
 Fax Number (816) 822-1723

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Non-Capital	Direct Cost	47	\$ 5,217,777	\$	2,904,075	\$ 119,992	1
2	34	Capital Building	Direct Cost	47	48,489		2,904,075	1,115	2
3	35	Capital Equipment	Direct Cost	47	252,330		2,904,075	5,803	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,518,596	\$		\$ 126,910	25

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CENTER # 0045948 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization TI-Dixon, LLC
 Street Address 7611 State Line Road, Suite 301
 City / State / Zip Code Kansas City, MO 64114
 Phone Number (816-444-0900
 Fax Number (816-822-1723

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>30</u>	<u>Depreciation</u>	<u>Direct Cost</u>	<u>1</u>	<u>\$ 35,246</u>	<u>\$</u>	<u>1</u>	<u>\$ 35,246</u>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 35,246	\$		\$ 35,246	25

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CE # 0045948 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle National Bank		X	Working Capital	\$5,357.00	8/2/2001	\$ 450,000	\$ 214,314	7/1/2002	P+.0025	\$ 16,384	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Interest Income										(40)	6	
7												7	
8												8	
9	TOTAL Facility Related				\$5,357.00		\$ 450,000	\$ 214,314			\$ 16,344	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 450,000	\$ 214,314			\$ 16,344	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **LEE COUNTY NURSING AND REHAB CENTER**# **0045948** Report Period Beginning: **1/1/2004** Ending: **12/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																
1. Real Estate Tax accrual used on 2003 report.		\$ 28,891	1																													
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 29,183	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ 292	3																													
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 31,810	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 32,102	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td>38,287</td><td>8</td></tr> <tr><td>2000</td><td>39,254</td><td>9</td></tr> <tr><td>2001</td><td>40,304</td><td>10</td></tr> <tr><td>2002</td><td>10,650</td><td>11</td></tr> <tr><td>2003</td><td>29,184</td><td>12</td></tr> </table>	1999	38,287	8	2000	39,254	9	2001	40,304	10	2002	10,650	11	2003	29,184	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2003 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2003 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1999	38,287	8																														
2000	39,254	9																														
2001	40,304	10																														
2002	10,650	11																														
2003	29,184	12																														
FOR OHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2003 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LEE COUNTY NURSING AND REHAB CENTER COUNTY LEE

FACILITY IDPH LICENSE NUMBER 0045948

CONTACT PERSON REGARDING THIS REPORT Junior Foster, THCSLLC, Mgmt Co.

TELEPHONE (816) 444-0900 FAX #: (816) 822-1723

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	07-08-04-376-011	Building	\$ 29,183.88	\$ 29,183.88
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ <u>29,183.88</u>	\$ <u>29,183.88</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

A. Square Feet:

28,700

B. General Construction Type:

Exterior

Brick & Block

Frame

Metal/Brick

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		28,700	2002	\$ 92,000	1
2					2
3	TOTALS	28,700		\$ 92,000	3

Facility Name & ID Number LEE COUNTY NURSING AND REHAB CENTER

0045948

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	91	2002		\$ 983,365	\$ 24,584	40	\$ 24,584		\$ 50,663
5									
6									
7									
8									
Improvement Type**									
9	WATER HEATER	2002		4,130	413	10	413		895
10	Water Softner	2003		5,536	554	10	554		1,107
11	Door Alarms	2003		3,577	358	10	358		716
12	Main entry landscaping	2004		5,482	274	10	274		274
13	Wallpaper entryway, living room	2004		9,997	833	5	833		833
14	Rounding			1					
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,012,088	\$ 27,016		\$ 27,016	\$	\$ 54,488	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number **LEE COUNTY NURSING AND REHAB CENTER** # **0045948** Report Period Beginning: **1/1/2004** Ending: **12/31/2004**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 87,235	\$ 11,401	\$ 12,925	\$ 1,524	Var	\$ 33,850	71
72	Current Year Purchases	10,834	1,197	1,197		Var	1,197	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 98,069	\$ 12,598	\$ 14,122	\$ 1,524		\$ 35,047	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,202,157	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,614	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,138	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,524	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 89,535	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	WIP	\$ 38,517	92
93			93
94			94
95		\$ 38,517	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease 0.

0
0

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 727

Description: See attached detail

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$
13. /2006 \$
14. /2007 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10a, 3	hrs	\$		919
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			32	1,693	45	32	1,738	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a, 3	hrs			1,753	82,625	208	1,753	82,833	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$	2,704	\$ 135,288	\$ 283	2,704	\$ 135,571		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 71,891	\$	1
2	Cash-Patient Deposits	13,664		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 34,714)	514,532		3
4	Supply Inventory (priced at)	7,678		4
5	Short-Term Investments			5
6	Prepaid Insurance	41,724		6
7	Other Prepaid Expenses	14,545		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from LOC Lender	154,533		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 818,567	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	61,757		14
15	Leasehold Improvements, at Historical Cost	5,482		15
16	Equipment, at Historical Cost	23,434		16
17	Accumulated Depreciation (book methods)	(9,473)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 81,200	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 899,767	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 85,566	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,664		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,522		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,701		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,810		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	(21,386)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 167,877	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	214,314		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 214,314	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 382,191	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 517,576	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 899,767	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 255,527	1
2	Restatements (describe):		2
3	Restatement of Prior Year to allow rollforward	854	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 256,381	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	261,195	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 261,195	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 517,576	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number LEE COUNTY NURSING AND REHAB CENTER # 0045948 Report Period Beginning: 1/1/2004

Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,345,416	1
2	Discounts and Allowances for all Levels	(345,482)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,999,934	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	312,055	6
7	Oxygen	1,656	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 313,711	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,798	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	128,550	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,539	19
20	Radiology and X-Ray		20
21	Other Medical Services	27,190	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 184,077	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	40	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 40	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	9,958	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,958	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,507,720	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	639,699	31
32	Health Care	1,415,546	32
33	General Administration	886,178	33
	B. Capital Expense		
34	Ownership	156,240	34
	C. Ancillary Expense		
35	Special Cost Centers	148,862	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,246,525	40
41	Income before Income Taxes (line 30 minus line 40)**	261,195	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 261,195	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **LEE COUNTY NURSING AND REHAB CENTER**# **0045948**Report Period Beginning: **1/1/2004**Ending: **12/31/2004****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	6,515	6,601	\$ 148,311	\$ 22.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,574	5,723	134,224	23.45	3
4	Licensed Practical Nurses	12,701	12,858	258,908	20.14	4
5	Nurse Aides & Orderlies	48,655	48,918	517,780	10.58	5
6	Nurse Aide Trainees	1,696	1,719	20,194	11.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,690	6,059	66,935	11.05	10
11	Social Service Workers	3,674	3,775	55,096	14.59	11
12	Dietician	16,919	17,026	138,653	8.14	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,908	1,964	24,294	12.37	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,976	2,008	54,164	26.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,859	3,923	72,646	18.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,455	1,487	12,480	8.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,622	112,061	\$ 1,503,685 *	\$ 13.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	183	\$ 8,114	1, 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	34	1,122	10, 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	72	2,324	11, 3	44
45	Social Service Consultant	40	2,724	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	329	\$ 14,284		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount	Description	Amount		
Traci Wagner	Admin.	0	\$ 49,517	Workers' Compensation Insurance	\$ 63,878	IDPH License Fee	\$	Advertising: Employee Recruitment	3,690		
				Unemployment Compensation Insurance		Health Care Worker Background Check (Indicate # of checks performed)					
				FICA Taxes	156,808			Dues & Subscriptions	3,103		
				Employee Health Insurance	51,554			Advertising & Public Relations	15,613		
				Employee Meals							
				Illinois Municipal Retirement Fund (IMRF)*							
				Other Benefits	1,610						
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,517								
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**					
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount			
Purchased Service		\$ 28,945		N/A		\$	Out-of-State Travel	\$			
Management Fees		210,461									
Legal Fees		700									
Accounting Fees		9,140					In-State Travel	5,022			
Data Processing		26,509									
Professional Services		765									

* Attach copy of IMRF notifications

**See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number **LEE COUNTY NURSING AND REHAB CENTER**

STATE OF ILLINOIS

0045948

Report Period Beginning: **1/1/2004**

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Ending: **12/31/2004**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,754
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 4,798
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.